Linda Cole
Chief, Long Term Care Policy and Planning
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

RE: Request for Informal Public Comment on COMAR 10.24.08 State Health Plan for Facilities and Services: Nursing Home, Home Health Agency, and Hospice Services.

Dear Ms. Cole:

Holy Cross Home Care and Hospice is pleased to have the opportunity to comment on the above document in reference to HOSPICE. As members of the Hospice Network of Maryland we support the comments sent by them and would like to submit these additional comments.

AVAILABILITY AND ACCESSIBILITY OF HOSPICE SERVICES

The Commission noted that the current supply of hospice programs seems adequate, but goes on to imply that this assumption should not apply to jurisdictions where there is only one hospice, i.e. rural areas. Based on the current need methodology there is no additional need for hospices in the rural jurisdictions that have only one hospice and, therefore, we recommend that the Commission not look for need where there is none. It is not clear to us that either policy makers or consumers are clamoring for additional choice in those areas and since no support is given for that comment it should be deleted.

The statements concerning "terminally ill patients, who are too sick to be discharged from the hospital" are troubling. In fact we have demonstrated that for those patients where leaving the hospital **is impossible**, it if far more cost effective to provide hospice care than keep them in an acute care mode of treatment. This is not an issue of "convenience" but an issue of providing the highest standard of care to patients at the end of life where ever they may happen to be. Patients and families who find themselves in an acute care hospital now have access to appropriate hospice care. They are able to receive the full spectrum of hospice services in the hospital setting. Rather than be a concern I would suggest that the Commission encourage and support the continuance of this program.

Policy 9.1 – the reference to "access issues" in jurisdictions with limited capacity makes little sense in light of the current need methodology outcomes as discussed above. It is not clear how calculating a separate volume threshold for rural and urban jurisdictions would lead to more access to hospice care in rural areas. Carroll County is the only

"rural" county showing additional need. There are 5 hospices in Carroll County. Using the current "net hospice need" of 168 means on average an additional 32.8 patients per hospice. These patients could easily be absorbed by the current hospices. We would recommend reevaluating the volume threshold being used. It would be important for the Commission to substantiate the perceived lack of access to hospice in rural jurisdictions with actual evidence in order to substantiate the significantly lower threshold.

Policy 10.0 addresses the need to find a better way of providing end of life care for children. We commend the Commission's policy to monitor the results of national data on this issue.

.13 Certificate of Need Docketing Rules:

c. CCRC Provider

This section sets up a separate process outside of the Commission's need methodology that allows a CCRC to apply for a HOSPICE CON to provide services to that CCRC's population. There are several concerns related to this. (1) Allowing additional Hospice agencies to serve only these populations eats away at the whole purpose and effectiveness of CON. For instance, does the need methodology then exclude those residents from the population calculations? If the Commission intends to set up a separate process to bypass the need methodology, it is critical that the process clearly define how need would be defined in this situation, as well as "cost effective" How would access to other providers be assured? (2) Hospices are already providing services to these populations with no demonstrated access issues, so how would an applicant demonstrate quantitatively that there exists an unmet need? (3) CCRC's by their nature "skim off" an elderly, more affluent population from the potential clients served by community hospices making it more difficult for those community hospices to provide charity care. (4) Although currently there is only one CCRC with an existing specialty home health agency allowing this exception sets a precedent for others coming into the market place. The number of CCRC's will likely increase in the future.

This policy inevitably will lead to a decrease in the ability of existing hospices to provide the high quality cost effective care they now provide. It will do nothing to help the disadvantaged and under served populations in the State that are being served by the current providers. We recommend it be deleted.

Thank you for the opportunity to comment.

Sincerely,

Margaret Hadley, RN, MSN
Director
Holy Cross Home Care and Hospice